California Department of Alcohol and Drug Programs
Office of Applied Research and Analysis

ALCOHOL AND OTHER DRUG PREVALENCE, CONSEQUENCE AND TREATMENT DATA BY RACE/ETHNICITY

2011 Report

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Introduction

The California Department of Alcohol and Drug Programs, Office of Applied Research and Analysis (OARA) created the following report focusing on alcohol and other drug (AOD) use, prevalence, consequence, and treatment-related data. Specific emphasis in this report is on identifying and understanding racial and ethnic differences among groups of individuals based on patterns of prevalence of AOD use and their treatment outcomes as reflected in the California Outcomes Measurement System-Treatment (CalOMS-Tx).

'Race' generally refers to perceived, distinctive differences between individuals or groups of individuals based on phenotypical characteristics, including skin color, facial features, and the like. In the literature, race is viewed as a social construct more than any meaningful biological or genetic differences between persons. However, this construct is thought by many to have meaningful impact on peoples' life experiences, and has been associated with documented differences in peoples' health, coping abilities, and their responses to social environments.

For this report, the definition and use of the term 'race' has been drawn from the definition adopted in 1997 by the federal Office of Management and Budget (OMB) and reaffirmed in 2008 by the U.S. Department of Education, which determined that

"Regardless of the race combinations of individuals, each individual must be counted in exactly one of the following race and ethnicity combinations when being reported to ED or other federal agencies:
- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Two or more races
- Hispanic of any race."

Ethnicity refers to similarities or differences between individuals or groups of individuals based on cultural traditions, practices, histories, and, at times, geographical backgrounds. Because of California's population dynamics, in this report, when data are distinguished by ethnicity, the comparison is typically between those identified as Hispanic relative to non-Hispanics.

In the data summaries that appear below, the OMB definition is used to summarize data, except in cases where the original race and ethnic categories data are not able to be disaggregated into discrete, non-overlapping groups.

OARA is dedicated to understanding and improving the Department's AOD programs, by analyzing data from ADP's CalOMS-Tx system as well as other publicly available data sources. The following report provides selected, key data for discussion. Most of these data reflect single-year snapshots of relevant information from national, state and departmental data sources. Future iterations of this report may include trend data to allow more detailed comparisons.

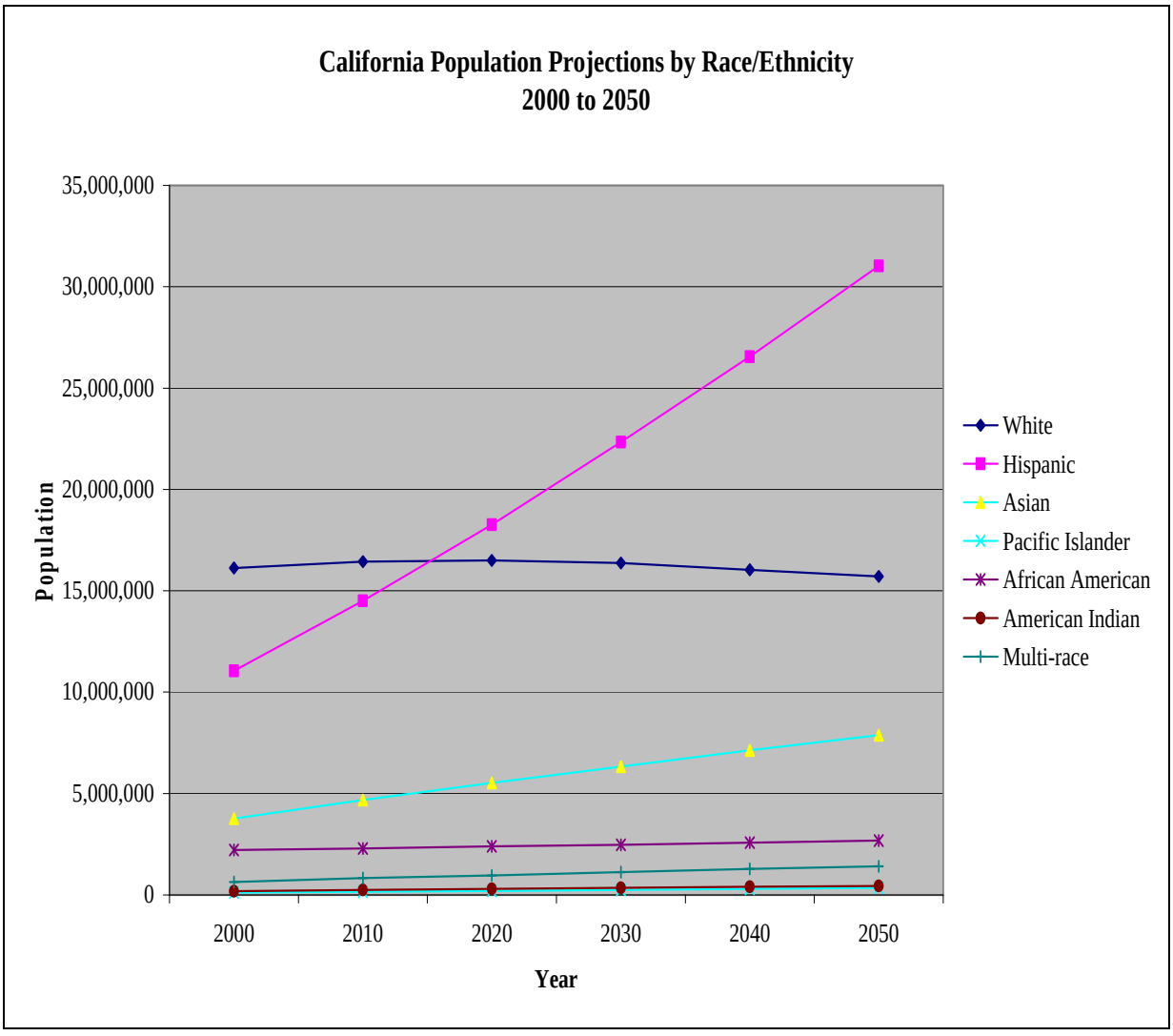
Race, Ethnicity and AOD-related Data

Population Projections in California, 2000 to 2050: Race and Ethnicity

Population projections for California over the next thirty-nine years reflect a continued increase in the number and diversity of the population. The most notable changes in California's population relates to its age, racial, and ethnic make up.

- Whites are the only population group expected to show declines over time. By 2040 the population of Whites is expected to decline.

- By 2020 Hispanics will outnumber non-Hispanics; by 2050 Hispanics will more than double the population of Whites.



Source: California Department of Finance.

The data regarding alcohol and other drug use are from several sources.

Alcohol and Other Drug Prevalence

Past Month Alcohol Use

- Nationally, in 2009, Whites (57%) and Multi-racial persons (48%) reported the highest levels of alcohol use, while American Indians/Alaska Natives (37%) and Asians (38%) reported the lowest. California-specific data on current (Past Month) alcohol use by Adults is not readily available.

Table 1: Alcohol Use in the Past 30 Days by Persons 12 or Older by Persons 12 or Older, United States, 2008 & 2009

	Alcohol Use, Past 30 Days US (2008)	Alcohol Use, Past 30 Days (2009)
Race/Ethnicity		
African American	41.9	42.8
American Indian / Alaska Native	43.3	37.1
Asian	37.0	37.6
Pacific Islander	*	*
Two or More Races	47.5	47.6
White	56.2	56.7
Hispanic or Latino	43.2	41.7
Total	**51.6**	**51.9**

* Low precision; no estimate reported.

Binge Drinking

- Nationally, in 2009, persons self-identifying as White, multi-racial, and Hispanic reported engaging in binge drinking at levels slightly higher than average. African Americans, American Indians or Alaska Natives, and, in particular, Asians, reported binge drinking at levels below the average.

- Among Californians, African Americans and Asians/Pacific Islanders reported binge drinking at substantially lower levels compared to most other racial/ethnic groups (20% and 21%, respectively)

Table 1-2: Binge Drinking by Persons 12 or older, United States and California, 2009

	Binge Drinking, US, (2009)	Binge Drinking, CA, (2005)[a]
Race/Ethnicity	%	
African American	**19.8**	**9.7**
American Indian or Alaska Native	**22.2**	**20.5**
Asian	**11.5**	**8.7**
Native Hawaiian or Other Pacific Islander	*	*
Two or More Races	**24.1**	**18.3**
White	**24.8**	**17.3**
Hispanic or Latino	**25.0**	**18.9**
Total	**23.7**	**16.4**

[a] Data about race/ethnic differences in binge drinking by Californians has not been collected recently. For males, binge drinkers are those that have had five or more drinks in the past month; for females, those that had four or more drinks.

Source: 2009 California Health Interview Survey. Retrieved from www.askCHIS.org July 2011. Los Angeles, CA: UCLA Center for Health Policy Research, April 2011.

Illicit Drug Use

- In 2009, the past month use of illicit drugs was reported more often by American Indians or Alaska Natives, followed by multi-race persons.

Table 1-3: Illicit Drug Use among Past Month Users Aged 12 or Older, by Race/Ethnicity, United States, 2009

Race/Ethnicity	Percentage of Use
African American	9.4%
American Indian or Alaska Native	19.4%
Asian	3.8%
Native Hawaiian or Other Pacific Islander	9.9%
Two or More Races	14.5%
White	8.9%
Hispanic or Latino	7.6%

Source: National Survey on Drug Use and Health, 2009, Office of Applied Studies, Substance Abuse and Mental Health Service Administration.

Concurrent Illicit Drug and Alcohol Use

- Use of illicit drugs while drinking is more common among American Indians or Alaska Natives than other racial or ethnic groups.

Table 1-4: Concurrent Illicit Drug and Alcohol Use among Past Month Alcohol Users Aged 12 or Older, by Race/Ethnicity, United States, 2006-2007

Race/Ethnicity	Percentage of Use
American Indian or Alaska Native	11.7%
Black	9.9%
Two or More Races	7.4%
Hispanic or Latino	5.4%
White	5.2%
Native Hawaiian or Other Pacific Islander	4.2%
Asian	2.1%

Source: National Survey on Drug Use and Health, using combined 2006-2007 data, Office of Applied Studies, Substance Abuse and Mental Health Service Administration.

Alcohol Use Among Women

These data (Table 1-5) are drawn from the California Women's Health Survey (CWHS), 2005-2009. The California Women's Health Survey (CWHS) is an annual statewide household-based telephone survey that collects information from a sample of approximately 4,000 randomly selected adult women on a wide variety of health indicators, including health related behaviors and attitudes. Similar data on men are not available.

- In 2009, 53% of women reported drinking alcohol during the past 30 days, reversing the downtrend evident since 2005.

- White women reported drinking significantly more in the past month than women, generally (62% compared to 53%, respectively).

- African American women drank at slightly higher levels than the state average, while Asian American/Other women drank slightly less that the state average.

- Alcohol consumption by all racial/ethnic groups increased in 2009 when compared to previous years, especially among African American and Asian/Other women.

Table 1-5: Percent of adult women who reported[a] any drinking during the past month, by age, race, and ethnicity, California, 2005-2009.

	2005	2006	2007	2008	2009
Race/Ethnicity					
African American	40.8	40.6	43.0	40.5	55.1
Asian/Other	42.0	36.2	32.0	28.1	52.5
White	63.8	61.5	60.6	59.4	61.9
Hispanic/Latina	35.9	31.0	30.2	28.3	33.9
TOTAL	**52.0**	**48.6**	**47.4**	**45.9**	**53.0**

[a]Weighted prevalence estimate of women reporting any drinking in the past month. Data are weighted according to the 2000 US Census for California women age 18 and over.

Source: California Women's Health Surveys, 2005-2009. Special data run by Maternal, Child, Adolescent Health Program's Surveillance and Program Evaluation Section, California Department of Public Health (CDPH) received June 2011.

Alcohol Use among Pregnant and Parenting Women

These data are drawn from the Maternal Infant Health Assessment (MIHA), 2005-2009. MIHA is an annual, population-based self-administered survey of about 3,500 women who recently gave birth to a live infant in California.

- In 2009, White women reported drinking substantially more (22.9%) during pregnancy when compared to others racial groups, while Asians/Pacific Islanders reported drinking less than other racial groups.

- Latina/Hispanic women reported drinking during pregnancy less often than non-Hispanics.

- Overall, slightly over 14% of women reported drinking alcohol during their pregnancy in 2009, a decrease from 2005.

Table 1-6: Percentage[a] of adult[b] women who reported drinking during pregnancy by race and ethnicity, California[c], 2005-2009.

	2005	2006	2007	2008	2009
Race/Ethnicity					
African American	15.5	16.3	13.0	16.8	14.8
Asian/Pacific Islander	9.4	14.9	n/a[d]	n/a[d]	11.6
White	28.6	20.5	14.6	24.7	22.9
Other	28.6	20.5	n/a[d]	n/a[d]	n/a[d]
Hispanic	10.9	8.2	4.6	7.3	9.7
TOTAL	**17.3**	**15.8**	**7.9**	**12.9**	**14.2**

[a] Percentages represent the proportion of women who report drinking in either the 1st and/or 3rd trimester.
[b] The estimates for race and ethnicity include data for the small group of women who participated in the survey younger than 18 years old.
[c] Survey response data are weighted to the California population of women who gave birth in 2005-2009, respectively.
[d] The sample cell size was < 20.

Source: Maternal Infant Health Assessment (MIHA) Surveys, 2005-2009. Special data run by Maternal, Child, Adolescent Health Program's Epidemiology, Assessment and Program Development Section, California Department of Public Health (CDPH), received July 2011.

Needing or Seeking Help for Emotional/Mental Health Problems or Use of Alcohol/Drugs

- In 2009, 14% of California adults reported needing help for emotional/mental health problems or use of alcohol and/or drugs.

- Californians identifying as multi-racial reported needing help more than other racial and ethnic groups (19%), followed by African Americans (17%).

- Multi-racial persons reported seeking help more than other racial and ethnic groups (16%), followed by American Indians or Alaska Natives (15%) and African Americans (14%).

- Asians and Pacific Islanders reported both needing and seeking help less often with emotional/mental health problems or problems associated with their use of alcohol or drugs.

Table 1-7: Adults Needing or Seeking Help for Emotional/Mental Health Problems or Use of Alcohol/Drugs, California, 2009.

Race/Ethnicity	%	
	Needed Help	Sought Help
African American	16.6	13.9
American Indian/Alaska Native	15.2	15.2
Asian/Pacific Islander	8.4	5.2
White	16.0	13.3
Two or More Races	18.6	16.0
Latino/Hispanic	13.4	9.0
Total	**14.3**	**10.9**

Source: 2009 California Health Interview Survey. Retrieved from www.askCHIS.org July 2011. Los Angeles, CA: UCLA Center for Health Policy Research, April 2011.

Summary

Based on the information provided, alcohol and other drug use vary by race and ethnicity**.**

Consequences of Drug Use: Drug Offense Arrests

Adult Misdemeanor Drug Offense Arrests by Race/Ethnicity, California, 2009

- In 2009, the rates of adult misdemeanor drug offense arrests for Marijuana, Other Drugs, Public Intoxication, and Liquor Law violations are highest among African Americans. This finding was particularly pronounced for misdemeanor marijuana and other drug offence violations, with rates over three and a half, and twice the rates of Whites, respectively, for these offenses.

Table 2: Adult Misdemeanor Drug Offense Arrests[a] by Race/Ethnicity, California, 2009

	Marijuana		Other Drugs		Public Intoxication		Liquor Laws	
	N	Rate[b]	N	Rate	N	Rate	N	Rate
Race/Ethnicity								
African American	9,102	583.8	10,484	672.4	10,855	696.2	1,017	65.2
White	17,731	154.3	33,105	288.0	55,444	482.3	6,731	58.6
Other	3,118	79.8	3,303	84.5	5,849	149.7	1,307	33.5
Hispanic	16,628	190.0	24,669	281.9	40,258	460.0	4,525	51.7
TOTAL	**46,579**	**181.2**	**71,561**	**278.3**	**112,406**	**437.2**	**13,580**	**52.8**

[a]The number of arrests per category. Age 18+.
[b] Rate calculation per 100,000 residents; based on Californians population between ages 10 and 69.

Source: Adult and Juvenile Arrests Reported, 2009; Criminal Justice Statistics Center, California Office of the Attorney General.

Adult Felony Drug Offense Arrests

- In 2009, African Americans had the highest arrest rates for all felony drug offenses. This finding was particularly pronounced for felony narcotics and marijuana drug offense arrests.

Table 2-1: Adult Felony Drug Offense Arrests[a] by Race and Ethnicity, California, 2009

	Narcotics[b]		Marijuana		Dangerous Drugs[c]		Other Drug Violations	
	N	Rate[d]	N	Rate Per 100,000	N	Rate Per 100,000	N	Rate Per 100,000
Race								
African American	16,006	1,026.6	4,308	276.3	4,704	301.7	276	17.7
White	12,541	109.1	5,288	46.0	22,893	199.2	528	4.6
Other	1,788	45.8	985	25.2	3,073	78.7	51	1.3
Ethnicity								
Hispanic or Latino	12,118	138.5	4,323	49.4	23,776	271.7	453	5.2
TOTAL	**42,453**	**165.1**	**14,904**	**58.0**	**54,446**	**211.8**	**1,308**	**5.1**

[a]The number of arrests per category, age 18+.
[b]Narcotics: Plant derivatives such as heroin, cocaine, etc.
[c]Dangerous Drugs: Manufactured drugs such as barbiturates, phencyclidine, methamphetamines, etc.
[d]Rate calculation based on Californians population between ages 10 and 69.

Source: Adult and Juvenile Arrests Reported, 2009; Criminal Justice Statistics Center, California Office of the Attorney General.

Adult and Juvenile Felony and Misdemeanor DUI[a] Arrests

- In 2009, Latinos/Hispanics had the highest rates of DUI arrests, follow by African Americans and Whites.

Table 2-2: Adult and Juvenile Felony and Misdemeanor DUI[a] Arrests[b] by Race and Ethnicity, 2008

	N	R[c]
Race/Ethnicity		
African American	16,458	1,055.6
White	82,482	717.6
Other	16,518	422.8
Hispanic	94,004	1,074.1

[a] DUI: Driving under the influence of alcohol, drugs, or the combination of alcohol and drugs.
[b] The number of arrests per category, age 18+.
[c] Rate calculation per 100,000 residents; based on Californians population between ages 10 and 69.

Source: Adult and Juvenile Arrests Reported, 2009; Criminal Justice Statistics Center, California Office of the Attorney General.

Consequences of Alcohol and Other Drug Use: Health

Alcohol-related Hospitalizations

- In 2009, Whites led in the rate of alcohol-related hospitalizations (124 per 100,000), followed by African Americans (76 per 100,000), American Indians/Alaska Natives (65 per 100,000), and Latinos/Hispanics (56 per 100,000). Compared to other groups, alcohol-related hospitalizations are relatively low among Asians/Pacific Islanders.

Table 3: Alcohol-related Hospitalizations, California, 2009

Race/Ethnicity	N	Rate per 100,000
African American	1,741	**76.4**
American Indian/Alaska Native	153	**65.0**
Asian/Pacific Islander	466	**9.8**
White/Other/Unknown	20,412	**124.2**
Latino/Hispanic	7,867	**55.5**
TOTAL	**30,639**	**79.2**

Source: In-Patient Discharge Data, 2009, Office of Statewide Health Planning and Development, California Department of Public Health (CDPH), Safe and Active Communities Branch. As measured by Primary Diagnosis (ICD-9CM).

Drug-related Hospitalizations

- In 2009, Whites had the highest rate of drug-related hospitalizations (112 per 100,000), followed by African Americans (88 per 100,000), American Indians (48 per 100,000), and Latinos/Hispanics (33 per 100,000). Compared to other groups, drug-related hospitalizations are relatively low among Asian/Pacific Islanders.

Table 3-1: Drug[a]-related Hospitalizations, California, 2009

Race	N	Rate per 100,000
African American	2,008	**88.1**
American Indian/Alaska Native	112	**47.6**
Asian/Pacific Islander	634	**13.4**
White/Other/Unknown	18,320	**111.5**
Ethnicity		
Latino/Hispanic	4,709	**33.2**
Total	**25,783**	**66.6**

[a]**"Drugs" only include those substances that have potential for abuse and dependence.**

Source: In-Patient Discharge Data, 2009, Office of Statewide Health Planning and Development, California Department of Public Health (CDPH), Safe and Active Communities Branch. As measured by Primary Diagnosis (ICD-9CM).

Alcohol-related Emergency Department Visits

- In 2009, Whites had the highest rate of alcohol-related emergency department visits (328 per 100,000), followed by African Americans (311 per 100,000), American Indians/Alaska Natives (199 per 100,000), and Latinos/Hispanics (190 per 100,000). Compared to other groups, alcohol-related emergency department visits are relatively low among Asians/Pacific Islanders.

Table 3-2: Alcohol-related Emergency Department Visits, California, 2009

Race/Ethnicity	N	Rate per 100,000
White/Other/Unknown	53,909	**328.0**
African American	7,093	**311.2**
Latino/Hispanic	26,889	**189.6**
American Indian	469	**199.2**
Asian/Pacific Islander	1,843	**38.8**
TOTAL	**90,203**	**233.2**

Source: Emergency Department Data, 2009, Office of Statewide Health Planning and Development, California Department of Public Health (CDPH), Safe and Active Communities Branch. As measured by Primary Diagnosis (ICD-9CM).

Drug-related Emergency Department Visits, California, 2009

- In 2009, African Americans had the highest rate of drug-related emergency department visits (168 per 100,000), followed by Whites (155 per 100,000). American Indians and Hispanics had very similar rates (67 per 100,000). Compared to other groups, drug-related emergency department visits are relatively low among Asians/Pacific Islanders.

Table 3-3: Drug-related Emergency Department Visits, California, 2009

Race/Ethnicity	N	Rate per 100,000
African American	3,821	**167.7**
American Indian/Alaska Native	158	**67.1**
Asian/Pacific Islander	774	**16.3**
White/Other/Unknown	25,523	**155.3**
Latino/Hispanic	9,465	**66.7**
TOTAL	**39,741**	**102.7**

Source: Emergency Department Data, 2009, Office of Statewide Health Planning and Development, California Department of Public Health (CDPH), Safe and Active Communities Branch. As measured by Primary Diagnosis (ICD-9CM).

Prevention/Early Intervention Need

Prevention and early intervention services are critical components of the continuum of services in California. The degree to which effective services are available will impact the future need for treatment services.

- Prevention strategies directed toward youth are especially important because there is a strong potential to avoid substance abuse problems before they start.
- Early intervention strategies such as Screening and Brief Intervention, Referral to Treatment (SBIRT)
    - reduce the risks and consequences related to alcohol and other drug use consumption
    - reduce high-risk AOD use; and,
    - increase motivation for behavioral change
    - can include strategies up to and including referral to specialized AOD treatment services.

CalOMS-Prevention (Pv) collects non-demographic and self-reported demographic data of participants engaged in prevention activities. The table below shows that

- Out of all prevention services delivered in SFY 2007/08, Latinos/Hispanics received the most prevention services while Pacific Islanders the fewest.

- However, when examining population service-based rates, the data show that race/ethnic groups represented in lower numbers within California's population receive a *higher* number of prevention services, within their group, when compared to larger population groups such as Hispanics and Whites.

Table 4: Persons served in Prevention

Race/Ethnicity	Persons Served	California Population	Rate Served Per 1,000 Population	Group's Percentage of Total California population
American Indian	9,138	224,927	40.6	0.6%
Asian	46,088	4,428,922	10.4	11.7%
African American	64,119	2,263,690	28.3	6.0%
Hispanic	218,306	13,539,990	16.1	35.8%
Pacific Islander	6,378	137,608	46.3	0.4%
White	191,787	16,423,530	11.7	43.4%
Other & Multiracial*	33,429	791,915	42.2	2.09%

Sources: California Department of Finance**;** California Outcomes Measurement System-Prevention, 2008-2009, California Department of Alcohol and Drug Programs (ADP); Special data run June 2011.

Unmet Alcohol and Drug Treatment Need

To better understand emerging issues regarding treatment, it is imperative to highlight the overall issue of AOD treatment need in our state. Consider the following:

- Approximately 3 million Californians age 12 and older need, but are not receiving, AOD treatment.
- Overall young adults 18 to 25 years of age have the highest percentage (24 percent) needing, but not receiving AOD treatment. They account for over one million people in need of treatment.
- Although the 26 and older age group has the lowest overall percentage (8 percent) needing treatment, it has the largest overall population: therefore, they account for nearly two million people in need of treatment.
- Males have a higher percentage and number needing, but not receiving treatment, than females.

Table 5: Unmet Treatment Need and Percentage of Unique CalOMS-Tx Clients by Race/Ethnicity, 2009.

Race/Ethnicity	2009 California Population (age 12+)	Percentage of Unique CalOMS-Tx Clients SFY 08-09	% Difference between CA Population and CalOMS Clients	Number/Percentage Needing but Not Receiving Tx for Illicit Drug or Alcohol
African American	1,927,834 (6.0%)	16.4%	10.4%	158,000 (8.2%)
American Indian/Alaska Native	211,174 (1.0%)	1.4%	0.4%	22,000 (10.2%)
Asian	3,952,810 (12.3%)	2.2%	-10.1%	150,000 (3.8%)
Pacific Islander	122,184 (0.3%)	0.2%	0.2%	*
White	14,503,410 (45.0%)	40.1%	-4.9%	1,218,000 (8.4%)
Hispanic	10,934,876 (34.0%)	35.4%	1.4%	1,006,000 (9.2%)

Sources: California Department of Finance**;** California Outcomes Measurement System-Treatment, 2008-2009, California Department of Alcohol and Drug Programs (ADP); National Survey on Drug Use and Health, 2008, Office of Applied Studies, Substance Abuse and Mental Health Service Administration.

Summary

African Americans account for over 16% of all unique clients in publicly monitored treatment in California, while they only comprise about 6% of the general population. What are the reasons for this difference? There are several possible explanations, and a few findings about African Americans in the CalOMS-Tx database may be relevant.

1. The extent to which African Americans utilize treatment services is paradoxical. Across several prevalence indicators it appears that they do not use alcohol and other drugs at levels higher than other groups. Therefore, one would not normally expect a (relatively) greater need for treatment when compared to other racial groups.

2. Moreover, African Americans are, indeed, disproportionally represented in arrest statistics for practically all misdemeanor and felony drug violations, despite being the least likely to be referred to treatment from criminal justice system.

3. Taken together, these data suggest that factors other than addiction or potential for addiction may be explanations for understanding why various populations groups—and African Americans in particular—are represented as they are in the publicly-monitored treatment in California. There seems to be evidence that suggests that economic differences among treatment clients may be a factor in explaining the difference. For instance, African Americans have the highest percentage of the major race/ethnic groups in treatment who are unemployed as well as the highest percentage of clients who are not in a stable living situation. They also have the lowest percentage of race/ethnic groups in treatment who report being Medi-Cal beneficiaries.

4. Further work is needed to determine how to best identify and to provide the treatment needs of African Americans, given the context of their social standing and their representation in AOD-related criminal justice consequences. While not analyzed in this report, recent NSDUH data demonstrates that the rate of need for treatment for an alcohol use problem in the past year among African American adults is similar to that of the national average among adults; however, the rate of need for treatment for an illicit drug use problem was higher among African American adults than the national average. Such differences in rates between illicit drugs and alcohol should be a point of further analyses in future reports of this type.

In a noteworthy parallel finding, the data show that Asian and Pacific Islander clients (API) account for only 2.4% of all unique clients in publicly monitored treatment in California, while comprising about 12.6% of the general population. Asian representation is particularly high in some states (including California), and are one of the fastest growing portions of the U.S population.

Prior research on API and substance abuse disorders suggest that they, as a group, have relatively low rates of alcohol use, alcohol dependence, and drug use, although considerable variation exists among Asian subgroups. In 2005, one researcher, Sakai, reported that clinicians often find API unlikely to use AOD treatment services.

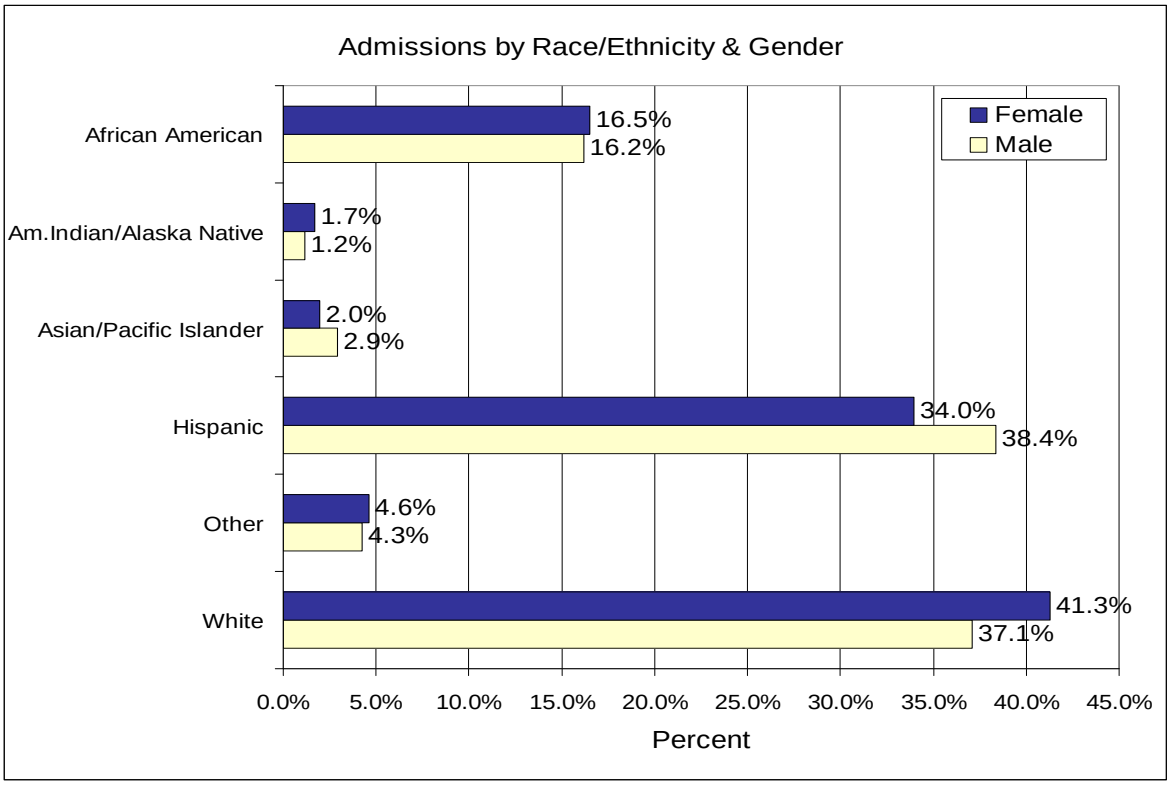
In CalOMS-Tx, Asian/Pacific Islanders are the most likely of the major race/ethnic groups to be referred to treatment from the criminal justice system; 50% of API clients in the treatment system come because of criminal justice referrals. This suggests that, without mandated treatment, API would be even more underrepresented in treatment than they are currently .

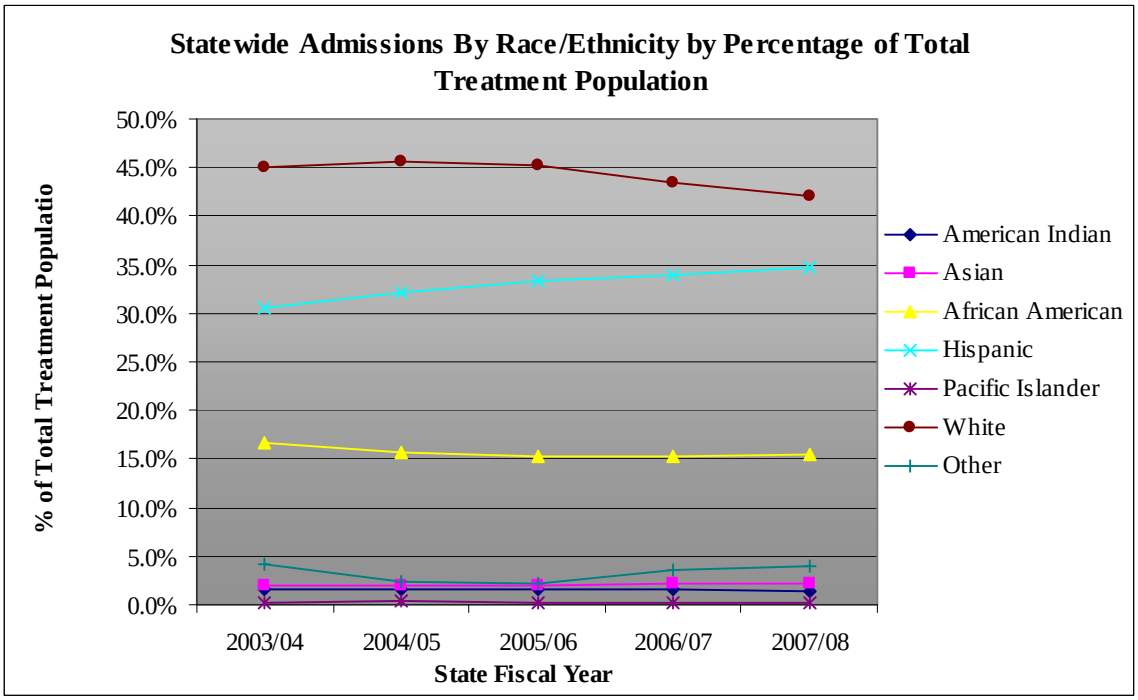
These findings about both African American and Asian/Pacific Islanders merit additional investigation.

CalOMS-Tx Admission Data

Client Admissions

The following graphs show admission percentages by primary drug for each race/ethnic subpopulation.





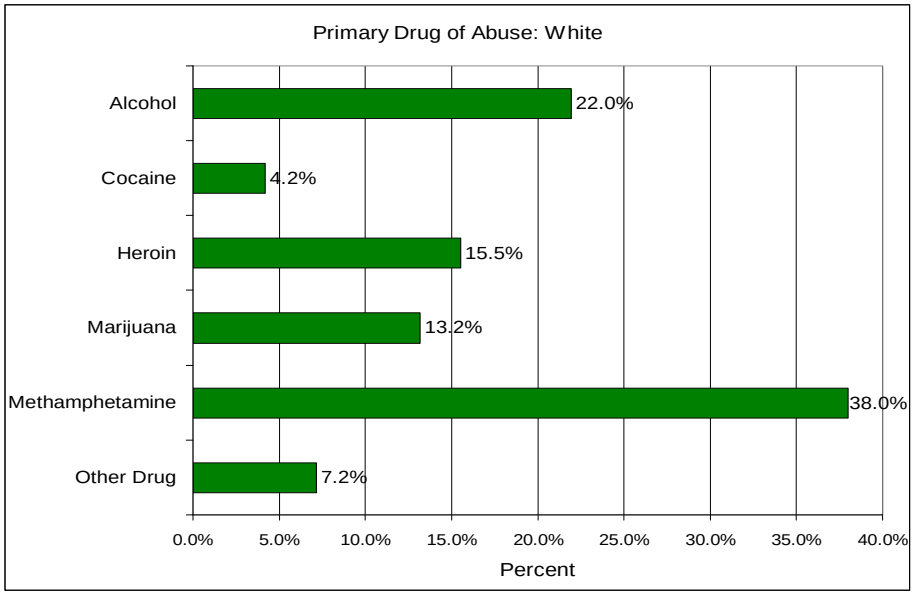
Summary

- Two race/ethnic subgroups – White and Hispanic – had the highest percent of admissions; Whites showed a pattern of steady decline while Hispanics showed a pattern of steady increase.

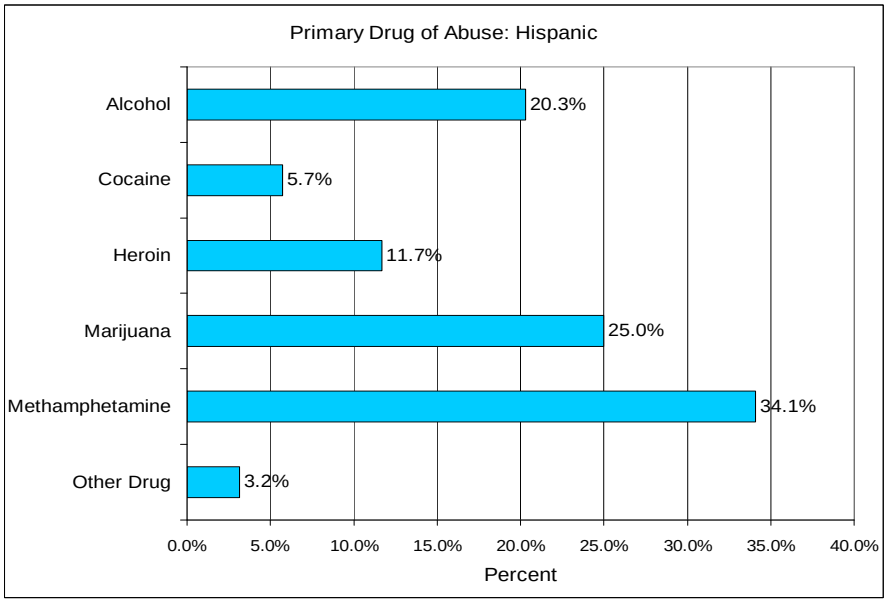
All other race/ethnic groups had noticeably lower percentages of admissions, except for African Americans.

Primary Drugs of Abuse

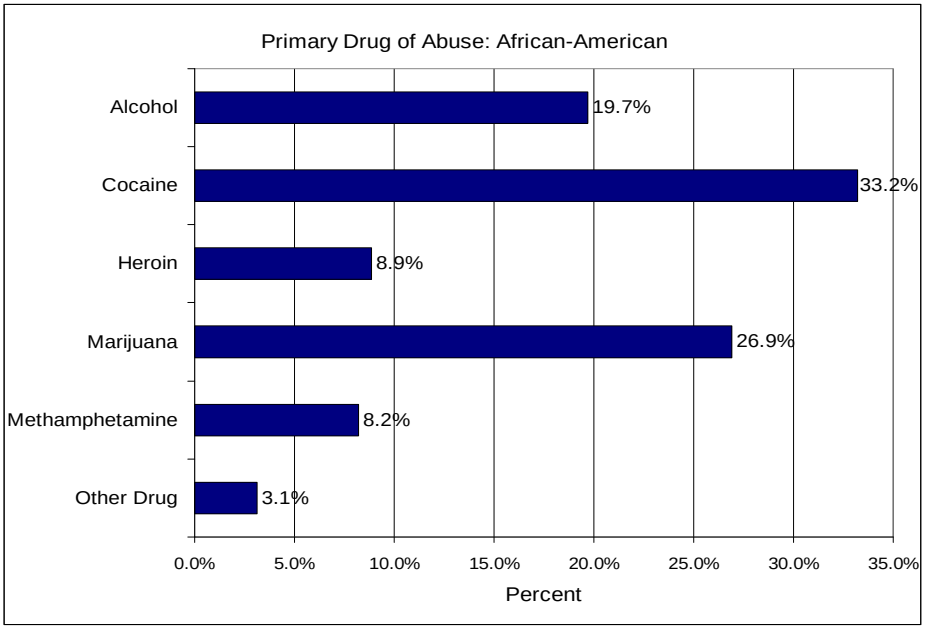
- **Whites** (70,276 admissions): As in the general population, Whites reflect the largest race subpopulation in treatment. Methamphetamine is the number one drug among this group (38.0%), followed by alcohol (22.0%) and heroin (15.5%).



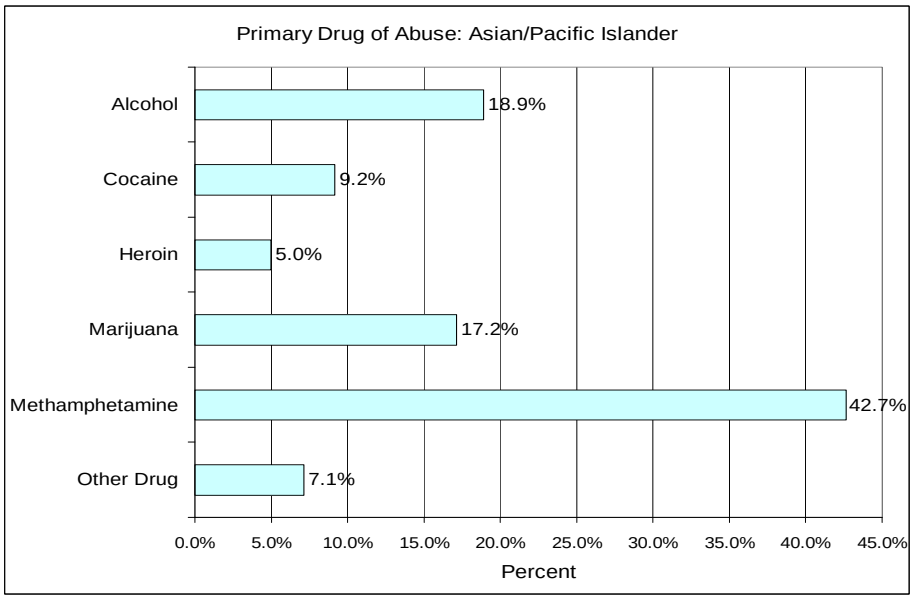
- ***Latinos/Hispanics*** (with 66,701 admissions): As in the general population, Latino/Hispanics reflect the second largest race/ethnic subpopulation in treatment. Methamphetamine is the primary drug at admission among this group, at 34.1%. In contrast to Whites, the second primary drug among Hispanics was marijuana (25.0%) followed by alcohol (20.3%).



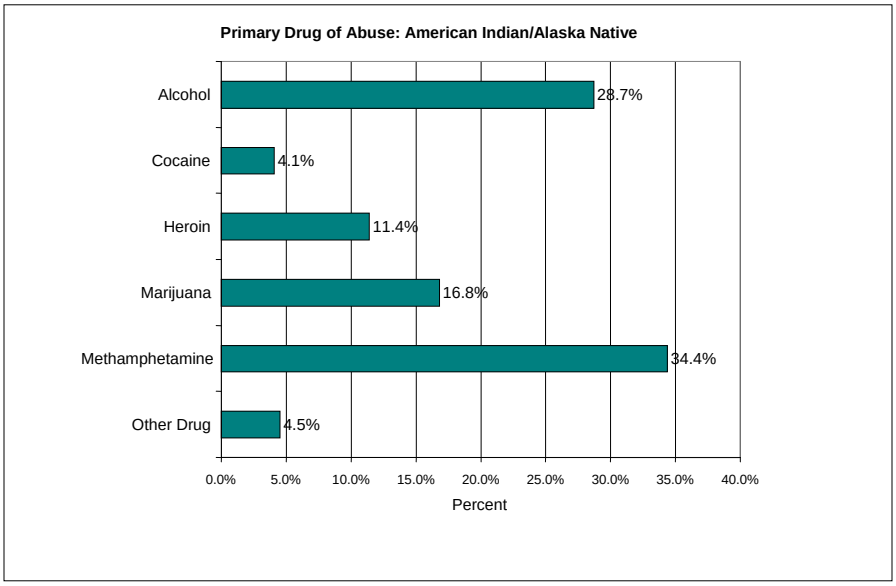
- ***African-Americans*** (29,635 admissions): African Americans reflect the third largest race/ethnic subpopulation in treatment. The graph below shows the percent of admissions for each primary drug reported by African-Americans at admission to treatment. In contrast to other subpopulations, the primary drug for African-Americans was cocaine (33.2%), followed by marijuana (26.9%) and alcohol (19.7%).



- ***Asian/Pacific Islander (A/PI)*** (4,653 admissions): The primary drug for A/PI is methamphetamine (42.7%). Compared with other race/ethnic treatment subpopulations, this group has the highest percent of admissions for methamphetamine. Alcohol (18.9%) and marijuana (17.2%) are the 2nd and 3rd most reported drugs driving treatment for A/PI.



- ***American Indian/Alaska Native*** (2,492 admissions): Among this group the top primary drug was Methamphetamine (34.4%), followed by alcohol (28.7%) and marijuana (16.8%).



Summary: Methamphetamine is the top primary drug reported at admission to treatment among all race/ethnic groups except African Americans, for whom cocaine is the most common. Alcohol is the second most commonly reported primary drug for Whites, A/PI and AI/AN, while it is marijuana for Latinos/Hispanics and African Americans.

Treatment Outcomes by Race/Ethnicity – CalOMS Tx SFY 08/09

Treatment Discharge Status by Race/Ethnicity

The following discharge status statistics exclude detoxification services since they are short term and considered a precursor to further treatment.

- CalOMS-Tx measures the percentage of discharges from treatment where the client completed the treatment goals for that treatment provider. The percentage completing their treatment goals vary across the race/ethnic groups. Overall, about 36% complete their treatment goals. Completion rates vary: 39% for A/PI and White clients; 37% for American Indian/Alaskan Natives; 35% for Hispanic; and 31% for African Americans.

- The percentage of discharges that do not complete but leave with satisfactory progress also varies slightly across race/ethnic groups. Percentages range from a high of 22% for African Americans to a low of about 17% for A/PI and Whites. These percentage ranges—i.e., those who do not complete treatment but leave with satisfactory progress--are almost the reverse of the completion statistics. Regardless of the race/ethnicity, a high percentage of those not completing treatment are referred to other treatment programs for further help.

- The percentage of discharges that do not complete treatment and do not make satisfactory progress varies slightly across the race/ethnicities, from a high of about 44% for African Americans and Hispanics to about 40% for A/PI. Again, regardless of the race/ethnicity, a high percentage of those not completing treatment are referred to other treatment programs for further help.

Treatment Length of Stay by Race/Ethnicity

- CalOMS-Tx measures the number of days the treatment client stays in individual modalities of treatment. Again, the following statistics exclude detoxification services since they are short term and considered a precursor to further treatment.

- Research shows that longer lengths of stay are positively related to better treatment outcomes, with 90 days or more of treatment being a general benchmark.

    - Overall, about 47% of the treatment discharges are for lengths of stay of 90 or more days.

    - And for those reporting that they completed the treatment goals, the percent staying 90 or more days is approximately 70%: this is conservative in the sense that residential providers are included in this analysis, and many of these clients transfer to outpatient treatment.

    - Lengths of stay that are for 90 or more days vary slightly by race/ethnicity - from 51% for A/PI to 46% for African Americans and Whites.

Summary

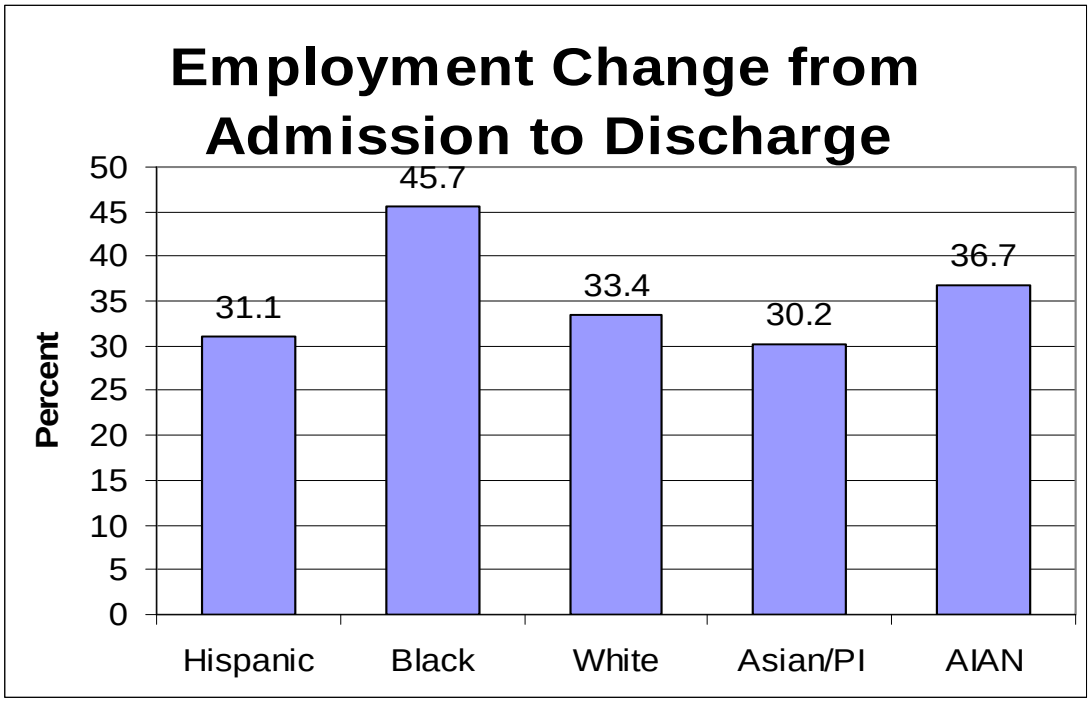
There are some differences between race/ethnicities in the percent completing treatment and lengths of stay. This analysis only examines one year of outcome data. Examining multiple years would be a next step to learn about trends. Future work to optimize AOD treatment services is important.

Treatment Outcomes by Race/ethnicity

In addition, below is a summary of improvements (treatment outcomes) from admission to discharge in six domains of client functioning. At admission, certain race/ethnic groups may have more problems in certain domains than other race/ethnic groups; these differences in admission problems (baseline) affect the percent change that is realized at discharge.

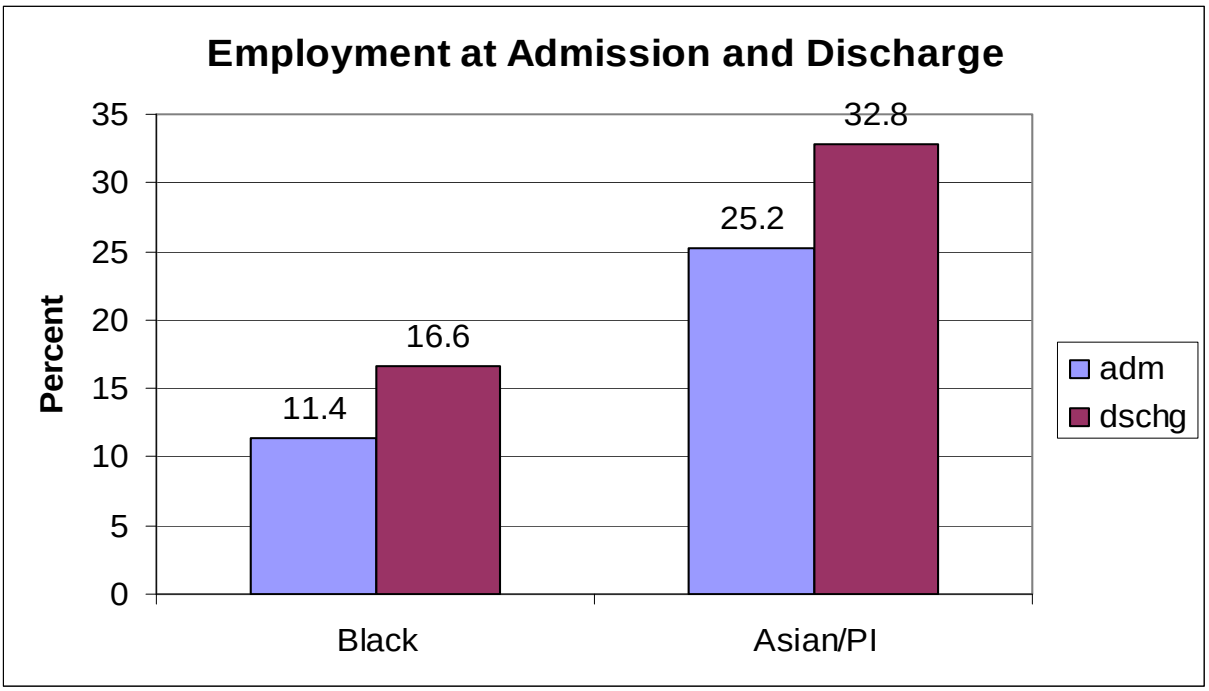
For instance if one race/ethnic group tends to face more unemployment than another at admission, then that group could realize larger proportional gains in employment (since change is measured by calculating the difference between the percent employed at discharge minus the percent employed at admission divided by the percent employed at admission (d-a/a)}. For instance, if one race/ethnic group has only 10% employed at admission, while for another race/ethic group 30% are employed at admission, the group with the lower percentage employed at admission has the potential to realize a larger overall percent increase.

The percent changes shown below, then, are relative to that race/ethnic groups' functioning in that domain at admission. Therefore, differences in a group's functioning must be noted and considered. The following provides an example for employment. We see that from admission to discharge African Americans, on average, show the largest percent increase in employment.



Employed - The percentage increase from admission to and discharge from treatment in those employed varies across race/ethnic groups from a low of 30.2% for A/PI to 45.7% for African Americans. However, the percent of African Americans employed at admission (11.4%) is the lowest of all the race/ethnicities.

Therefore it is important to understand that after treatment each race/ethnic group is making progress in the employment area, but it is relative to their level of functioning at admission. Employment, then, is a significant issue for each of the race/ethnicities, although from different levels of functioning at admission. Research shows that employment is important to helping clients achieve and maintain long term recovery.



Treatment Outcome Domains by Race/Ethnicity

SFY 0809 CalOMS TX					
% Change Admission to Discharge					
Treatment Outcome Domains	**Hispanic**	**African. American.**	**White**	**A/PI**	**American Indian**
No Use Prior 30 days	61.0	68.2	67	57.3	59.4
	48.7%-78.5%	45.9%-77.2%	46.5%-77.7%	51.7%-81.3%	49.8%-79.3%
No Arrest	11.3	11.1	12.0	13.3	13.0
	86.9%-96.7%	87.4%-97.1%	86.2%-96.5%	86.1%-97.6%	85.1%-96.2%
Employed	31.1	45.7	33.4	30.2	36.7
	21.5%-28.2%	11.4%-16.6%	22.7%-30.2%	25.2%-32.8%	16.2%-22.2%
Social Support	69.9	74.9	46.2	63.3	48.8
	36.9%-62.7%	36.9%-64.6%	49.2%-71.9%	38.4%-62.7%	48.8%-72.6%
Independent Living	8.8	11.7	11.5	8.9	13.5
	35.2%-38.2%	32.7%-36.5%	40.9%-45.6%	35.2%-38.3%	43.6%-49.5%
No Health Problems	5.5	6.7	9.4	4.6	10.8
	87.2%-92.0%	83.1%-88.7%	79.8%-87.3%	89.7%-93.8%	78.1%-86.5%

a. % at admission and discharge

- **No Use Prior 30 Days -** The percentage increase in abstinence from admission to and discharge from treatment varies across race/ethnic groups from a low of 57.3% for A/PI to 68.2% for African Americans. As noted above, though, the percent of Asians reporting no drug use at admission was the highest (51.7%) of all the race/ethnic groups, while African Americans reported the lowest percent (45.9%) among those reporting drug use at admission. This difference makes direct comparisons of this outcome between race/ethnicities difficult. Nevertheless documenting these differences is an important step to improved understanding of changes in clients' lives related to treatment, and how to improve the cultural relevance and effectiveness of the services.

- **No Arrests -** The percentage increase from admission to and discharge from treatment in those with no arrests varies slightly across race/ethnic groups from a low of 11.1% for African Americans to 13.3% for A/PI. However, the percent without arrests at admission is very high for all race/ethnic groups (85-87%) Therefore the opportunity for improvement for the group at discharge is limited. Future analyses could perhaps look at just those clients with arrests at admission to focus on race/ethnic differences.

- **Social Support -** Research shows that participation in social support programs, such as 12-step and other self-help meetings, is associated with positive treatment outcomes and long-term, sustained recovery from AOD dependence and abuse. The percentage increase (from admission to and discharge from treatment) in those participating in social support programs varies across race/ethnic groups from a low of 46.2% for Whites to 74.9% for African Americans. However, the percent of Whites participating in social support programs at admission (49.2%) is much higher than for African Americans (36.9%). This difference makes direct comparisons of this outcome between race/ethnicities difficult. Nevertheless the data show important improvements after treatment. And, documenting these differences is an important step to improved understanding of changes in clients' lives related to treatment, and how to improve the cultural relevance and effectiveness of the services.

- **Independent living -** Like employment, independent living is often considered a longer term goal of recovery. "Independent living" refers to living in a stable living environment and contributing to the living costs. Many clients entering treatment are homeless or involved in dependent living situations (dependent living is especially common for criminal justice referred clients –many were in controlled environments). The percentage increase from admission to and discharge from treatment in those living independently varies across race/ethnic groups from a low of 8.8% for Hispanic to 13.5% for American Indian/Alaskan Natives. The percent of clients at admission that are in an independent living situation varies across race/ethnicities for a low of 32.7% for African Americans to a high of 43.6% for American Indian/Alaskan Natives. It is interesting that only for this domain the same race/ethnicity has both the highest percentage at admission and change at discharge.

- **No Physical Health Problems -** The percent without reported health problems at admission is fairly high for all race/ethic groups. The percent ranges from 78.1% for American Indian/Alaskan Natives to 89.7% for A/PI. Percent increases from admission to discharge range from a low of 3.9% for Asians to a high of 10.8% for American Indian/Alaskan Natives. Again these percent changes are related to the baseline percentage.

Summary

These data reveal positive outcomes across all race/ethnicities for a number of import life domains. This information also shows that there are differences in the average levels of problems in functioning for each of the race/ethnicities at admission to treatment, and in the percent increase in functioning from admission to discharge.

While we have made great strides to focus on and improve the continuum of services, it is important to learn more about why these differences in outcomes by race/ethnicity exist. One area of potential benefit is further improving the implementation of culturally competent services to optimize the AOD field.

Conclusion

This initial report aims to present AOD-related data commonly used by ADP, considering the demographic characteristics of race and ethnicity. From a public health perspective these data are important because they provide, at least initially, insight into whether race- and ethnic-specific patterns exist with respect to AOD use (and associated problems), and/or client treatment experiences and outcomes.

The data sources reported here are diverse, and further analyses are warranted. In most cases it is difficult to clearly distinguish among Californians with respect to AOD-related consequences. Certain patterns bear further investigation:

- Whites tend to use and are impacted by alcohol in ways that distinguish them from other groups.
- Asians (but not necessarily Native Hawaiians and Other Pacific Islanders)—at least as seen in several of the data sources presented—tend to be use AOD at levels generally lower than other groups.
- African Americans are arrested at higher levels than others for AOD-related offenses, especially for drug-related offenses.

A complex set of factors may be at work that do not allow for identifying 'underlying' causes of alcohol and drug use behavior, or even the toll of that behavior. In fact, it is unclear whether all 'consequences' can always be causally linked to drug use at all. For instance, there are several potential reasons why African Americans are arrested for drug violations at much higher rates when compared to other groups, such as the types of communities where these arrests occur, policing practices, the adjudication process, etc.

A public health approach will require further investigation into the patterns of use (prevalence) along with looking at the types and severity of consequences, whether health, economic, social or otherwise. Further investigation is also needed to better understand treatment needs and how to improve program performance and client outcomes by identifying and understanding racial and ethnic differences.